DDM ND Retrospective Review Form

Patient Name:

Axis IV: Psychosocial and Environmental Problems: (check all that apply)

- ☐ Problems with primary support group *Specify*: _____
- ☐ Problems related to the social environment *Specify*: _____
- ☐ Educational problems *Specify*: _____
- ☐ Occupational problems *Specify*: _____
- ☐ Housing problems *Specify:* _____
- ☐ Economic problems *Specify:* _____
- ☐ Problems with access to Health Care Services *Specify:* _____
- ☐ Problems related to interaction with the legal system *Specify:* _____
- ☐ Other psychosocial and environmental problems *Specify:* _____

Axis V: CAF _____ HAF _____

Medications (Psychiatric/Behavorial Only): (List drug name, dosage, purpose, and dates used)

Precautions: _____ Frequency of Checks: _____

Current symptoms requiring inpatient care:

Chronic behaviors:

Description of Treatment:

I affirm all information provided is a true and accurate description of the above named individual.

Signature: _____

DDM North Dakota Under 21 Retrospective Review Form

Hospital/Facility Name: _____ Phone: _____
Contact Person: _____ Date Sent to DDM: _____
Date of Admission: _____
Type: (check one) ☐ **Acute Elective** ☐ **RTC** Date of Discharge: _____
☐ **Acute Emergency**

Patient Name: _____ Date of Birth: _____
Social Security #: _____ Medicaid #: _____
Gender: ☐ Male ☐ Female

Responsible Party Name: _____
Relationship: ☐ Self ☐ Parents ☐ Court ☐ Gov. Agency ☐ Other:
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ County: _____
Living Arrangements Prior to Admission:
☐ Alone ☐ Court ☐ Other: _____
☐ Relatives ☐ Non-Relatives
☐ Group Home ☐ Spouse
☐ Parents ☐ Foster Home

Marital Status:
☐ Married ☐ Separated
☐ Single ☐ Widowed
☐ Divorced

Prior Inpatient Treatment: ☐ Yes ☐ No (if "yes", list dates, frequency, facility, outcome)

Prior Outpatient Treatment: ☐ Yes ☐ No (if "yes", list dates, frequency, facility, outcome)

Admission Status:
☐ Elective ☐ Court-Ordered
☐ Emergency

☐ Home ☐ Group Home
☐ Foster Home ☐ Acute Hosp.
☐ RTC Hosp. ☐ Psych Hosp.
☐ Unknown ☐ Other: _____

Attending Physican: License #:

Admitting Diagnosis:
Axis I: _____
Axis II: _____
Axis III: